Examining the letter of the law for billing

Navigating the labyrinth of state and federal healthcare billing laws can feel daunting for OMSs. With evolving regulations and complex reimbursement processes, understanding the following laws is essential for compliance and avoiding costly mistakes.

False Claims Act

The False Claims Act (FCA), established in 1863, targets fraud against the U.S. government. It penalizes anyone who knowingly submits false claims or falsifies records to receive government payments. Examples include filing claims for services not rendered or billing for a more expensive procedure than what was performed, also known as upcoding. The FCA includes a whistleblower provision, allowing individuals to sue on behalf of the government and receive a portion of recovered funds. Violations may result in civil monetary penalties and/or criminal penalties, including imprisonment. The Fraud Enforcement and Recovery Act (FERA) of 2009 expanded the FCA's scope by broadening liability for false claims, including those made to third parties using government funds; strengthening whistleblower protections; and increasing penalties for fraud.

Anti-Kickback Statute

The Anti-Kickback Statute (AKS) criminalizes offering, paying or receiving anything of value (e.g., money, gifts, rebates) for patient referrals or influencing purchases of services covered by federal health programs (e.g., Medicare, Medicaid, TRICARE). Safe harbors protect certain practices if they meet specific criteria. For example, regularly waiving copays and advertising this practice can violate the AKS. Violations can result in fines, jail time and exclusion from federal programs unless specific safe harbor requirements are met.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, or the Stark Law, prohibits doctors from referring Medicare, Medicaid or other federal health plan patients for certain designated health services (DHS) to entities with which they or their immediate family have a financial relationship (such as ownership, investment or compensation) unless an exception applies. Violations can result in fines and exclusion from federal health programs. The law, named after former U.S. Rep. Pete Stark, restricts referrals for 12 DHS categories including clinical lab services, physical therapy, radiology and outpatient prescription drugs. An in-office ancillary services exception allows group practices to provide and receive compensation for imaging services. The Patient Protection and Affordable Care Act (PPACA) added a requirement for doctors to inform Medicare patients in writing about alternative imaging providers, listing at least five within a 25-mile radius. For more information, visit CMS.gov/medicare/regulations-guidance/physician-self-referral.

Civil Monetary Penalties Law

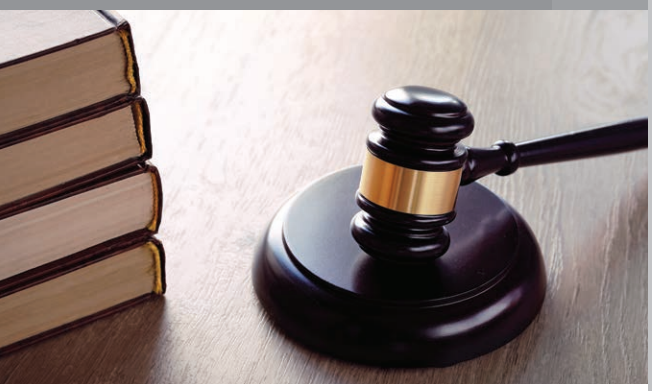
The Civil Monetary Penalties Law (CMPL) allows the Office of Inspector General (OIG) to seek penalties ranging from $10,000 to $50,000 per violation for various offenses, including submitting false claims, violating the Anti-Kickback Statute, breaching Medicare agreements, providing misleading discharge information, failing to screen emergency patients adequately and making false statements on federal health program applications. Penalties also can include exclusion from federal health programs.

No Surprises Act (NSA)

Enacted in 2022, the No Surprises Act (NSA) introduced federal protections to reduce unexpected medical bills, especially when patients lack a choice of in-network providers. It set new standards for balance billing, patient communication and cost estimates for healthcare providers, including OMSs. The NSA also established a dispute resolution process for payment disagreements. Many states have their own, potentially more stringent, surprise billing laws. AAOMS outlines key provisions of the NSA at AAOMS.org/practice/practice-management/payment-policies and encourages OMSs to consult with their practice attorneys to understand the impact of both federal and state laws.

Affordable Care Act (ACA)

Most providers are aware that the Affordable Care Act (ACA) mandates the expansion of insurance coverage for essential benefits including preventive services, mental healthcare and chronic diseases. However, lesser-known ACA mandates require providers participating in Medicare, Medicaid or the Children's Health Insurance Program (CHIP)



to report and return identified overpayments within 60 days and to establish compliance programs demonstrating their commitment to prevent, detect and correct fraud, waste and abuse. Measures include written policies and procedures, designation of a compliance officer and compliance committee, training and education, effective lines of communication, enforcement of standards, auditing and monitoring, and prompt response to detected offenses and corrective action. Managed care contracts and some state insurance codes also may dictate the handling of overpayments and recoupment.

Ensuring compliance

Staying current on correct coding guidelines, Medicare and other insurers' payment policies, and managed care contract terms as well as becoming familiar with various state and federal billing laws is crucial for OMSs to ensure compliance and avoid costly penalties. Some states also enforce mandates that offer providers protection from common managed care contract provisions. However, these mandates are outside the scope of this article.

Violation of federal and state laws also may be deemed unethical under the AAOMS Code of Professional Conduct.

AAOMS offers many courses and resources, including *AAOMS's Insurance Manual: Comprehensive Billing and Reimbursement Guide for the OMS*, to navigate coding and third-party reimbursement issues. Members also are encouraged to consult legal experts to ensure best practices to maintain compliance. ■